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HIV/AIDS STIGMATIZATION ON RELATIVES AND ASSOCIATES OF PEOPLE LIVING WITH HIV/AIDS: A PSYCHOLOGICAL STUDY

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ABSTRACT: *The present study examined HIV/AIDS stigmatization on relatives and associates of people living with HIV/AIDS in Ghana. After seeking informed consent from relatives and associates of HIV/AIDS patients on hand at the Korle-Bu Teaching Hospital, using purposive sampling technique, a sample of 60 responded to the HIV Stigma Scale and the Depression, Anxiety and Stress Scale. One Way Analysis of variance, Pearson Product Moment Correlation and Independent t-test were the statistical tools used for the analysis of the 3 hypotheses. Analysis of results indicates that no significant difference exists between the levels of stigma experienced by various associates of patients with HIV/AIDS. However, female associates of children with HIV/AIDS experienced more stigma than their male counterparts. The study found no significant relationship between stigma level and psychological distress among relatives and associates of the patients living with HIV/AIDS. From the Ghanaian setting, it is conclusive that regardless of the nature of relationship existing between people living with HIV/AIDS and their significant others, some level of stigma is still experienced across board. The implications of the study were discussed in line with the literature and the concept of Indigenous Cultural and Family Insurance*.

KEYWORDS: HIV/AIDS Patients, Stigmatization, Associates, Psychological Distress, Korle-Bu Teaching Hospital, Indigenous Cultural and Family Insurance Concept, Ghana.

INTRODUCTION

It goes without saying that HIV/AIDS is as much about social phenomena as it is about biological and medical concerns. Across the world, the global pandemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities. But the disease is also associated with stigma, ostracism, repression and discrimination, as individuals affected (or believed to be affected) by HIV have been rejected by their families, their loved ones and their communities (Joint United Nations Programme on HIV/AIDS, (UNAIDS) 2000). This rejection holds as true in the rich countries as well as in the poorer and developing countries (UNAIDS, 2000). Ogunmefun, Gilbert, Schatz (2011) found that older women as caregivers were being stigmatised. HIV/AIDS related stigma remains a cause for concern. HIV stigma has been largely seen to have been projected on the infested individual as they get rejected by some loved ones and family. Research has largely neglected its impacts on the significant others and associates surrounding these individuals. HIV/AIDS-related stigma refers to prejudice, discounting, discrediting, and discrimination directed at people perceived to have AIDS or HIV, and the groups and communities with whom they are associated (Herek, 1999). This comes closely with the concept of discrimination which refers to an unfair and unjust treatment of an individual based on his/her real or perceived HIV status (UNAIDS, 2003).

Gilmore and Somerville (2007) also conceptualized four different stages of stigmatization in sexually transmitted diseases. These stages, argued, cover the at least four processes any stigmatizing response takes. First, is the problem which can be described as the discredited attribute (Goffman, 1963), which can also be described as distinguishing and labellizing (Link & Phelan, 2001). The second stage is identifying the people living with HIV/AIDS (PLWHA) for targeted discrimination. It means the discriminated person must be recognizable in the society with some identifiable characteristics which can be used to label them correctly or erroneously. Third stage has to do with the target person who is labeled with the stigma. The target person is perceived as immoral and blamed for their predicament. The fourth stage has to do with the response of the stigmatized person. Here the person may be distanced, disempowered or controlled by the stigmatizer. The effect of stigmatization on HIV/AIDS patients is wide ranging and can be very devastating. Visser, Makin, Vandormiael, Sikema and Forsyth (2009) argued HIV related stigma threatens and to undermine interventions. Visser et al. (2009) concluded that stigmatising attitudes are affected by socio-demographic characteristics. According to Simbayi, Kalichman, Strebel, Cloete, Henda, Mqeketo , (2007) the effects of internalized AIDS stigmas have not been investigated in Africa, home to two-thirds of the more than 40 million people living with AIDS in the world. Few works done from the Ghanaian context on the subject uses either descriptive statistics or adopts a qualitative approach. The present study adopted a qualitative approach. It is clear that little is known from Ghanaian setting about the stigma attached to the relatives and associates of the person living with HIV/AIDS. Little research attention has been given to the evaluation of the impact of HIV patients on the lives of their close associates. Most academic research has often concentrated on the individual (patient) affected with the disease. However, it is obvious that many more than the number infested by the condition suffer stigma and discrimination for the fact that their relative or friend or otherwise close person is an HIV/AIDS patient. This provides the footing for the holistic understanding of how wide the effect of the disease goes and employs the necessary approaches to help affected persons and their relatives.

Aims of the Study

The current study was guided by the following aims

- To find out if any difference exists in the level of stigma experienced by direct relatives and other associates of people living with HIV/AIDS
- Ascertain whether any gender differences exist in the level of stigma experienced by relatives and associates of people living with HIV/AIDS
- To examine the effect (psychological) of HIV stigma on relatives and associates of people living with HIV/AIDS

LITERATURE REVIEW

Theoretical Underpinnings

Stigma Theory

The present study employed Goffman's Theory of Stigma in explaining the variables in this study. Goffman (1980) explained that stigma causes an individual to be mentally classified by others in an undesirable, rejected stereotype rather than in an accepted, normal one. In essence, stigma is a special kind of gap between virtual social identity and actual social identity (Goffman, 1980). Goffman (1980) argued that society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories. The theory explains the circumstances that precipitate stigma as from the angle of the one stigmatizing. Such is the situation with the infested person and very likely the associates around such patient.

Indigenous Cultural and Family Insurance Concept

Social insurance in its usual usage refers to any government-sponsored program geared toward assisting the underprivileged in society. According to the encyclopedia Britannica, Social Insurance is a public insurance arrangement that provides protection against various economic risks such as loss of income due to sickness, old age, or unemployment and in which participation is compulsory. Social insurance is considered to be a type of social security. As an illustration, the first compulsory social insurance programs on a national scale were established in Germany under Chancellor Otto von Bismarck in three categories: health insurance in 1883, workmen's compensation in 1884, and old-age and invalidity pensions in 1889 (*www.britannica.com/EBchecked/topic/551273/social-insurance*). Germany's example was soon followed by Austria and Hungary. And overtime many nations followed the trend. Otto von Bismarck's initiative was good. However, in most collectivist cultures, an indigenous form of insurance has existed long before as part of their cultural leanings. Li (1999) argues that the human society started with family insurance. Taking care of the elderly has been one of the key functions of families (Li, 1999). The researchers conceptualize this not only as a family responsibility but as a heritage handed over to subsequent generations. It therefore becomes a way of life. In the opinion of the researchers, this is an ***"Indigenous Cultural and Family Insurance"***. This idea tend to explain why majority of people within the Ghanaian setting being it relatives, friends and others associates readily come to the aid of members in the event of loss of income due to sickness, unemployment, suffering from an ailment, old age, or death of a member. It is a norm that such members rally behind the person in need to assist in all angles. Fellow feeling makes the immediate society share a responsibility to invest their time and other resources in caring for members in need to ensure their happiness and well being. The attachment make such close associates assumes the position of the person in need. On a grandeur application of this "Indigenous Cultural and Family Insurance" as proposed by the researchers, it is expected that the stigma attached to the person living with HIV/AIDS be extended to the relatives and other associates of the said patient.

Related Studies

Studies on the impact of HIV/AIDS have focused mainly on the individual, especially on preventing HIV/AIDS, and on strategies for individuals infected with HIV to cope with the disease. Infection with HIV, however, also has an impact on the individual's family (Bor, du

Plessis & Russell, 2004). This impact depends on the way in which HIV spreads among communities (and who it infects), the prognosis of infection, and the social setting in which the individual and family live. Visser et al. (2009) argued that socio-demographic factors affect Stigmatising. Respondents who were more stigmatising were the older, male and less educated and less knowledgeable (Visser et al., 2009). Ogunmefun, Gilbert, Schatz (2011) studied empirically stigma of caregivers in South Africa. However, they largely focused on older women as many HIV/AIDS caregivers are older women. Ogunmefun et al. (2011) found many acts of stigmatizing against these older women including isolation, finger-pointing and being gossiped about. Turan, Bukusi, Onono, Holzemer, Miller, and Cohen (2011) concluded that HIV/AIDS stigma is a common thread in the narratives of pregnant women affected by HIV/AIDS globally and may be associated with refusal of HIV testing. Simbayi, Kalichman, Strebel, Cloete, Henda, Mqeketo , (2007) examined the prevalence of discrimination experiences and internalized stigmas among 420 HIV-positive men and 643 HIV-positive women recruited from AIDS services in Cape Town, South Africa. Once again the emphasis was on the affected victims. According to Koku (2010) participants reported. In their study, Miles, Gillespie and Holditch-Davis (2007) results showed that, younger age, more conflict, less social support, lower perception of health, and more HIV worry were associated with depression. Personal variables were the highest among all categories that determined the rate of depression of the PLWHA.

Deacon and Stephney (2007) conducted a research which suggests that stigma and discrimination can exacerbate the material and psychological problems children already face in the context of the HIV/AIDS pandemic (Gernholtz & Richter, 2004). Stigma can prevent proper access to education, well-being, treatment and care both directly (through abuse, denial of care, forced child labour and loss of inheritance), and indirectly (if children avoid potentially stigmatising situations such as social interaction, healthcare and educational opportunities because they expect or internalise stigma) (Strode & Barrett-Grant, 2001). Stigma, discrimination and courtesy stigma directed towards adults can affect the ability of caregivers to provide proper psychosocial and material support for children infected or affected by HIV/AIDS (Juma, Okeyo & Kidenda, 2004). Adults may suffer even more and so will be their caregivers, relatives and other associates (Juma, Okeyo & Kidenda, 2004). It is intriguing to pre-empt the findings of this subject area from the Ghanaian setting.

In Ghana, HIV is common among the economically active population. Specifically, adults between the ages of 15 and 49 are the most affected group (National AIDS/STI Control, 2001). In terms of gender, females are the most affected category in Ghana, with two-thirds of reported cases being females. Women who have been diagnosed with HIV usually need time to come to terms with the diagnosis. For this reason most of them do not disclose their status. This type of reaction provides evidence for issues such as the stigma surrounding HIV (WHO, 2009). Often people with HIV suffer in silence because they are afraid that people will reject or discriminate against them (Parker, Aggleton, Attawell, Pulerwits & Brown, 2002). Studies done by Mokokah (2000) and Van Dyk (2008) revealed that varying emotional reactions follow individual's diagnosis of HIV positive such as grief, shock, anger, guilt, sadness, embarrassment and fear. Studies done by Sadoh and Sadoh (2009) indicated HIV/AIDS affects physical, emotional, social and economic wellbeing of the individual. The question that remains unanswered by Sadoh and Sadoh (2009) is the extent to which associates of the person living with HIV/AIDS get affected psychologically. All the above findings are usually found to be associated with the individual suffering from the disease.

However, the same experiences can be extended to the associates and relatives of the persons living with HIV/AIDS. Li, Wu, Wu, Jia, Lieber and Lu (2008) and Mitchell and Knowlton (2009) veered off from this initial research direction a little bit. Li, et al. (2008) conducted a study to examine the impact of HIV-related stigma on families living with HIV/AIDS in China. HIV/AIDS stigma was reported to have major impacts on family identity and interactions. The small sample size (45) used by Li et al. (2008) given the population of China, demonstrates the involvedness of getting respondents for such a sensitive research area.

Mitchell and Knowlton (2009) also examined relationships among caregiver stigma, disclosure, and depressive symptoms in a cross-sectional sample of 207 informal caregivers of people living with HIV/AIDS (PLWHAs). Results indicated that among caregivers, HIV care giving-related stigma was associated with more depressive symptoms, while disclosure of care giving status was associated with fewer symptoms. They concluded that these results suggest the need for interventions to address high levels of depressive symptoms among informal HIV caregivers. The literature so far has not provided a comparison in the level of stigma suffered by the direct relatives and other associates of the HIV/AIDS patient. The concern is often about the stigma the patients themselves face. It is worth conducting a research to find out the extent to which relatives of HIV/AIDS patients get affected in the Ghanaian setting to see how findings compares with similar studies elsewhere as a way of addressing the gap relating to applicability.

Rationale for the Study

The estimated number of people living with HIV/AIDS in Ghana in 2009 were 267, 069 made up of 154, 612 females and 112, 457 males. Again in 2009, there were 25,666 children living with HIV/AIDS and an estimated number of 3,354 children were newly infected. In an era where HIV/AIDS is becoming a common epidemic but with rising consequences on the individual in question and relatives and significant others, it is imperative that the issue be looked at beyond the affected person(s). In essence, the extent of stigma must be looked at from a collective and communalistic view. The present study aimed at widening the scope of study on the condition and adding more knowledge to the subject matter. The peculiar rationale is to identify how much people who are not infested with the HIV condition suffer directly or indirectly from the condition of others for the mere fact that they are associated with them through blood or society. Ghana is a society where individuals easily inter-depend on each other. As such, the life of one person can affect the lives of many people in the society.

Statement of Hypotheses

Based on the theories and literature reviewed, the researchers came out with the following hypotheses

- Relatives of people living with HIV/AIDS will experience more stigma than their other associates
- Female associates of people living with HIV/AIDS will experience more stigma than males
- Those who experience more stigma will be more psychologically affected (stressed. anxious and depressed) than those who experience less stigma

Operational Definition of Terms

Relatives of people living with HIV/AIDS: these are people who are biologically and directly related to an individual infested with the virus

Associates of persons living with HIV/AIDS: these includes friend, mates and acquaintances of individuals infested with the virus

Stigma: this is the derogatory perception, remarks and treatment given to people due to their affiliation with an HIV/AIDS patient

Psychological distress: the feeling of emotional disturbance s such as anxiety, depression and levels of stress

METHOD

Sample/Sampling Technique

The study population for this research was all the relatives and friends of HIV/AIDS patients receiving treatment at the Child Health Department (HIV/AIDS Unit) of the Korle-Bu Teaching Hospital in Accra. From the population described above, a sample of sixty (60) was purposefully selected for the study. Usually, parents, relatives or other associates of children with HIV/AIDS at the Child Health Department (HIV/AIDS Unit) of the Korle-Bu Teaching Hospital are present with them to take care of them. From among these relatives, caregivers and other associates who visit, the sample was selected for the study. Respondents were however sampled using convenient sampling technique. This is a sampling method that allowed respondents to be selected based on their availability and willingness to participate in a study (Babbie, 2004). By using this technique, respondents were selected based on their willingness to participate.

Instruments

The first section (A) sought data regarding respondent's demographics such as age, gender, relation with HIV/AIDS patient, duration of sickness and completed level of education
Section (B) of the questionnaires was the HIV Stigma Scale developed by Berger (1996). This scale measured perceived stigmatization. This is a 40 item-scale rated on a 5-point likert, ranging from strongly agree to strongly disagree. It has a reliability of 0.82 (Berger, 1996). The minimum and maximum possible scores expected were 40 and 160 respectively.

The Depression, Anxiety and Stress Scale-DASS, a three dimension self report measure with 14 items by Lovibond and Lovibond (1995) was used to measure stigmatization. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, and lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Respondents were asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state over the past week. Scores for Depression, Anxiety and Stress were calculated by summing the scores for the relevant items. The following reliabilities; to be 0.91, 0.81, and 0.88 for Depression, Anxiety and Stress respectively (Daza et al., 2002; Crawford & Henry, 2003)

Research Design

The research was a correlational study aimed at establishing relationships between variables (perceived stigma and impact of stigma). In this design, respondents' level of stigma perception were recorded and correlated with their scores on the impact of the perceived stigma which was measured in the domains of anxiety, depression and stress.

Procedure for Data Collection

This present study was carried out in the Child Health Department (HIV/AIDS Unit) of the Korle-Bu Teaching Hospital. To obtain permission to conduct the study, an introductory letter of clearance was sent to the Management of Korle-Bu Teaching Hospital for institutional approval. When granted permission, respondents were given informed consent forms and there after the questionnaires were administered to relatives and associates who came to visit their patients in the department. This was done purely on a voluntary basis with regards to the respondents. Therefore, it is only those willing to participate that were recruited for the study. Data was gathered and subjected to analysis.

Ethical Considerations

Ethical regulations outlining professional guidelines for the conduct of research were strictly adhered to in this study. First and foremost, informed consent form was signed by all respondents. Participants were made aware that information gathered would be used only for the purpose for which it was collected - to advance knowledge in research and where possible serve as a guide to policy makers. Respondents were assured that any personal information obtained will be treated confidential. Generally, all aspects of the research was conducted in conformity to laid down regulations as enshrined in the American Psychological Association's (APA) code of conduct (2002) for such a sensitive research.

RESULTS

Analysed results of the data collected from the research field are presented below.

Table1: Demographic Information of Respondents

Characteristic	Frequency	Percentage
Gender		
Male	28	46.7
Female	32	53.3
Age (mean, SD)	31.8 (11.69)	
Level of education		
Basic	28	35
Secondary	14	17.5
Tertiary	30	37.5
Duration of sickness (mean, SD)	4.9 (2.267)	
Relation with patient		
Parent	2	3.3
Sibling	45	75.0
Friend	9	15.0
Friend's child	4	6.7

In the above table, it is observed that more females than males were used for the study (32 and 28 respectively). Participants used were of the mean age of 31.8 (SD= 11.69). Majority of them had tertiary education (37.5%) whereas majority are siblings of the patients (75%).

Hypotheses Testing

Hypothesis One

Hypothesis one stated that relatives of people living with HIV/AIDS will experience more stigma than their other associates. This hypothesis was tested using the One-Way ANOVA because four different groups (parent, sibling, friend, friend to child's parent) were being compared on stigma. The results are presented in tables 2 and 3 below.

Table 2: Descriptive Statistics of Relatives and Associates of the HIV/AIDS Patients.

Category	**N**	**Mean**	**SD**
Parent	2	93.00	.00
Sibling	45	93.82	7.06
Friend	9	96.00	6.56
Parent's Friend	4	97.50	3.00

In the mean scores presented above, it is found that friends of the parents of the child recorded the highest score on stigma (Mean= 97.50, SD=3.00 where the parents recorded the least (mean=93.00, SD=0.00). Result of the mean differences tested by the One-Way ANOVA is presented in table 3 below.

Table 3: Summary of One-Way ANOVA Results

Source	Sum of Squares	*df*	Mean Square	*F*	*p*
Between Groups	80.36	3	26.79	.59	.63
Within Groups	2561.58	56	45.74		
Total	2641.93	59			

From the ANOVA result presented above, it was found that there is no significant effect of type of relationship one has with HIV patient and the level of stigma experienced [$F_{(3,56)}$= .59, *p*= .63]. The first hypothesis was therefore not supported.

Hypothesis Two

The second hypothesis, the researchers posited that 'female associates of people living with HIV/AIDS will experience more stigma than males'. The independent t-test was used to analyze the hypothesis because two independent groups (males and females) were involved. The result is presented in table 4 below.

Table 4: Independent t-test Comparing Males and Females on Stigma

Variable	**Male (40)**	**Female (40)**	**t**	***p***
	Mean (SD)	**Mean (SD)**		
Stigma	92.60 (4.31)	95.90 (8.47)	2.20	.02*
Depression	16.73 (10.48)	16.60 (8.16)	.06	.48
Anxiety	15.28 (10.01)	18.83 (8.53)	1.71	.05*
Stress	17.15 (9.88)	18.95 (9.38)	.84	.20

**** significant at .05***

From the table above, a significant difference is observed between the scores of males (Mean=92.60, SD=4.31) and females (Mean= 95.90, SD=8.47) on stigma [$t_{(78)}$=2.20, *p*= .02]. The Means indicate that female's record higher stigma than males. Further from the table, it is observed that no significant gender difference on depression [$t_{(78)}$= .06, *p*= .48] and stress [$t_{(78)}$= .84, *p*= .02]. There is however a significant difference between males and females on anxiety [$t_{(78)}$=1.71, p= .05] where females recorded higher (Mean= 18.83, SD=8.53) than their male counterpart (Mean= 15.28, SD=10.01).

Hypothesis Three

The third hypothesis was analyzed using the Pearson Product Moment Correlation Coefficient. The result is presented below in tables 5 and 6.

Table 5: Means and Standard Deviations of Study Variables

Variable	N	Mean	SD
Age	60	31.80	11.69
Stigma	60	94.37	6.69
Depression	60	17.50	9.07
Anxiety	60	17.97	9.12
Stress	60	19.20	9.50

Table 6: Correlation Matrix showing Relationship between Study Variables

	Age	Stigma	Depression	Anxiety	Stress
Age					
Stigma	.03				
Depression	-.22*	.18			
Anxiety	-.18	.18	.91**		
Stress	-.25*	.20	.91**	.92**	

From table 6, it is shown that a significant negative correlation exists between age and depression (r= -.22, *p*< .05) and stress (r= -.25, *p*= < .05). Even though a positive correlation exist between stigma and depression (r=.88), it was not significant (*p*>0.05). No significant correlation also exists between stigma and anxiety (r= .18, *p*> .05). There is no significant relationship between stigma and stress (r= .20, *p*> .05). The hypothesis in this case is not supported.

Summary of Main Findings

- No significant difference exists between the level of stigma experienced by various associates of patients with HIV/AIDS
- Female associates of children with HIV/AIDS experienced more stigma than their male counterparts.
- No significant relationship exists between stigma level and psychological distress.

DISCUSSION

This study investigated the level of stigma experienced by the significant people (relatives and associates) around people living with HIV/AIDS. The present study found no significant difference exists between levels of stigma experienced by various associates of patients with HIV/AIDS. This finding contradicts the findings of Li et al., (2008). Li et al. (2008) argued in their study that relatives of family members of HIV/AIDS patients experience a lot of stigma. Per the findings of this study all people (relatives and other associates) of persons living with HIV/AIDS all tend to experience almost equal levels of stigma. This means that the range of people who are affected by the stigma is wide. This agrees with Herek (1999), who indicated that other people apart from the infested individual also suffer stigma. This raises serious concerns and calls for extensive action in curbing the menace.

The above finding was however not surprising in the Ghanaian setting and likely may be congruent with many collective cultures. The proposed "Indigenous Cultural and Family Insurance" to a large extent explains why the first hypothesis had little support from the Ghanaian perspective. Majority of people around the person living with HIV/AIDS, being it relatives, friends and others associates readily assumes the role of a caregiver and a sympathizer as part of our way of life. Similar gesture is extended to all members in the event of loss of income due to sickness, unemployment, suffering from an ailment, old age, or death of a member. It is a norm that such members rally behind the person in need. Fellow feeling makes the immediate society share a responsibility to invest their time and other resources in caring for members in need to ensure their happiness and well being. It therefore presupposes that this hypothesis is culture specific and setting dependent.

Female associates of people living with HIV/AIDS experienced more stigma than males. The National AIDS/STI Control (2001) identified that demographic factors affect the level of stigma experienced by both the patients and their associates. Specific mention was made of age and gender. This indicates that gender is a strong factor in the level of stigma people associated with HIV/AIDS patients. Women's vulnerability is often clear in most cases where threat is apparent. They may not have the ability to resist the societal pressures that accompany their association with people living HIV/AIDS. Thus, they will feel more stigmatized against than males who on the other hand will considerably be able to endure the pressures.

Women are culturally seen to be caring and natural sympathizers. Most men are likely to support the person in need but in most cases financially. The women largely do so by time investment in their role as caregivers in the event of sickness or an ailment on the part of a family member. Unfussy observation from the Korle-Bu Teaching Hospital reveals that most caregivers are females. Such women are close to the person living with HIV/AIDS. It is therefore not surprising those female associates of the person living with HIV/AIDS experienced more stigma than their male counterparts.

Contrary to the research prediction, no significant relationship was found between stigma level and psychological distress. It was found that a positive but not significant relationship exists between stigma and depression, anxiety and stress. This means that level of stigma does not predict the psychological distress among relatives and associates of people living with HIV/AIDS, contradicting the findings of Koku (2010) and Mitchell and Knowlton (2009) who found stigma among HIV patients' associates and depression. Deacon and

Stephney (2007) indicated that stigma presents with psychological problem aside material difficulties. Some of these psychological problems may be depression, anxiety and stress. It was expected that the stigma that comes from the society will resent some discomfort for the associates and relatives of people living with HIV/AIDS. As such, they will have to endure a lot of emotional pain and stress. This will result in anxiety and subsequent depression. However, even though there were significant positive relationships found between depression, anxiety and stress among the participants, this relationship did reflect on stigma. Many Ghanaians takes solace from their strong religious beliefs. Appreciating the strong belief of God's power to undo all adverse experiences in life makes many Ghanaians resilient and robust psychologically. This likely provides a basis for the little support for the extent to which associates of the person living with HIV/AIDS were psychologically affected.

IMPLICATION FOR THEORY AND PRACTICE

It is imperative for advocacy programmes and the fights being mounted on the epidemic to cover the relations and friends of the patients. This research unravels the challenges other people other than the patient go through. This study is invaluable to most Non Governmental Organizations (NGOs) and other governmental organizations in their policy formulations and implementations. For instance, attention should largely be given to assisting female caregivers as they are more likely to be stigmatised. Furthermore, this study serves as an education to the general public on the fact that stigmatizing against people living with HIV/AIDS does not have a singular effect on the person living with the condition alone but also on many other people surrounding the individual. Above all, the present study adds to the repertoire of literature from the Ghanaian perspective.

LIMITATIONS OF THE STUDY

The present study was challenged in a number of ways. One of the limitations is that the study used only the quantitative approach. Even though study of such nature bothers on respondents reputations and flash back of emotions making it difficult for many to respond to research demands, the sample size was quite small. However, the use of a sample of 45 by Li et al. (2008) in a similar study in the Chinese setting with huge population demonstrates the challenge in engaging associates of a person living with HIV/AIDS. A second contributory challenge to the small sample size was the fact that the study was conducted at a time when Ghana medical doctors were on a nationwide strike for a period of six weeks and few patients were allowed to report only on grounds of emergency. Some respondents were not interested giving some necessary information on the questionnaires administered. It was also noted that many of the respondents were relatives or friends of child HIV/AIDS patients. All these limited the scope and nature of respondents for the study. These however do not invalidate the findings brought forth by this research.

RECOMMENDATIONS FOR FUTURE RESEARCH

Stigma associated with HIV/AIDS is a serious thing and requires deeper investigation and intervention. It is imperative that an empirical qualitative approach be used to conduct research on stigma to unravel the form or nature of stigma experienced by friends and associates of the infested patient. Future researchers are urged to use interviews or focus group discussions to unearth the nature, scope and form of stigma. A comparative approach could also be done to check the extent of variations in stigma as experienced by the patient as against the friends and relatives. Finally, it must be recommended that future studies in this field employ a larger sample size and possibly use friends and relatives of adults HIV/AIDS patients for any varying results. The researchers also proposes that future researchers apply the proposed concept of “Indigenous Cultural and Family Insurance” in explaining other practices within most communal settings.

SUMMARY AND CONCLUSIONS

This study unravelled three main findings based on the aim of investigating the prevalence and effect (psychological) of HIV stigma on relatives and associates of people living with HIV/AIDS. Conclusions drawn from the findings include the fact that regardless of the nature of relationship existing between people living with HIV/AIDS and their significant others, some level of stigma is still experienced across board. It is arguably conclusive that the level of stigma does not necessarily translate into psychological distresses among associates and relatives of persons living with HIV/AIDS. The present findings contributes to a more culturally nuance understanding of Stigma in HIV/AIDS studies. This study brings to the fore that variations in the level of stigma of relatives and associates of HIV/AIDS patients are culture specific and setting dependent. Aligning finding of this study with existing literature, the researchers posit that the extent of stigma variations among male and female associates remains inconsistent and research must be advanced in this area.

REFERENCES

Bor, R., du Plessis, P, & Russell, M. (2004). The impact of disclosure of HIV on the index patient's self-defined family. *Journal of Family Therapy,* 26(2):167–192.

Crawford, J. R. & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology*; 42:11–131

Deacon, H. & Stephney, I. (2007). *HIV/AIDS, stigma and children A literature review.* Human Sciences Research Council. Cape Town; HSRC Press

Encyclopedia Britanica (www.britannica.com/EBchecked/topic/551273/social-insurance-retrived on 15/10/13)

Gernholtz, L. & Richter, M. (2004). Access of abandoned children and orphans with HIV/AIDS to antiretroviral therapy – a legal impasse, *South African Medical Journal,* 94(11): 910–912

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Prentice-Hall.

Herek, Gregory M. and John P. Capitanio. (1999). “AIDS Stigma and Sexual Prejudice.” *American Behavioral Scientist.* 42(7):1126-1143.

Juma, M., Okeyo, T. & Kidenda, G. (2004). '*Our hearts are willing, but'. Challenges of elderly caregivers in rural Kenya*. Nairobi: Population Council

Li, L (1999). Family Insurance or Social Insurance Policy Options for China’s Social Security Reform. International Journal of Economic Development, 1(4), 431- 450

Li, L., Wu, Z., Wu, S., Jia, M., Lieber, E., Lu, Y. (2008). Impacts of HIV/AIDS stigma on family identity and interactions in China. *Family System Health*. 26(4):431-442.

Lovibond, S. H. & Lovibond, P. F. (1995). *Manual for the Depression anxiety Stress Scales. (2nd Ed.)* Sydney: Psychology Foundation

Miles, M. S., Gillespie, J. V., & Holditch-Davis, D. (2007). Assisting HIV-positive African American mothers. *Journal of the Association of Nurses in AIDS Care*, *12*, 42-50.

Mitchell, M. & Knowlton, A. (2009). Stigma, disclosure, and depressive symptoms among informal caregivers of people living with HIV/AIDS. *AIDS Patient Care STDs*, 23(8): 611-617.

Robertson, B. A. & Ensink, K. (1992). The psychosocial impact of human immunodeficiency virus infections in children, *Southern African Journal of Child and Adolescent Psychiatry*, 4(2): 46–49

Simbayi, L. C., Kalichman .S, Strebel . A.,Cloete, A. Henda, N., Mqeketo .A. (2007)Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science and Medicine*, 64, 9, 1823–1831

Visser, M. J., Makin, J. D, Vandormael A, Sikkema KJ, Forsyth BW.(2009). HIV/AIDS stigma in a South African community, Pub Med

Turan, J. M. , Bukusi, E. A., Onono, M., Holzemer, W. L., Miller, S. & Cohen, C. R. (2011) HIV/AIDS Stigma and Refusal of HIV Testing Among Pregnant Women in Rural Kenya: Results from the MAMAS Study. *Aids Behaviour*, 15, (6), 1111-1120

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